

# UNDER THE MICROSCOPE

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## Recent CMS Announcements on Medicaid Signal Major Opportunities for County Behavioral Health and ID/DD Services

### ISSUE.

This issue of Under the Microscope highlights three of the most significant – and least well-understood – CMS Medicaid announcements of 2016:

- CMS letter regarding clarifications to the Medicaid Inmate Exclusion
- HHS Medicaid Managed Care regulation and its modification of the IMD rule
- CMS Innovation Center's announcement of Accountable Health Communities Grants

Taken together, these announcements and the new funding, research, care, and service opportunities they create, represent enormous and positive progress for the behavioral health and ID/DD fields. The object of this Under the Microscope issue is to help clarify these major changes, identify the important opportunities that they create, and assist county behavioral health and ID/DD directors and their colleagues to formulate urgent and effective responses.

### ANALYSIS

Six years of non-stop reforms following passage of the Affordable Care Act, shaped in part by the effective work of many behavioral health and ID/DD advocates including the National Association of Counties and NACBHDD, continue to result in the promulgation of important policy changes and opportunities for behavioral health and ID/DD leaders nationwide. Three of the most important recent changes improve the ability of counties to fund care for justice-involved individuals, provide inpatient care for those in crisis due to behavioral health concerns, and explore the health impact of identifying and meeting the social service needs of Medicaid beneficiaries through the new Accountable Health Communities Model.

#### 1. Clarification of “Inmate Exclusion” expands eligibility for justice-involved individuals

Changes are still rippling through state and county systems as a result of an important CMS letter, dated April 28, 2016, that clarifies the conditions under which an individual is deemed to be an “inmate of a public institution” and therefore ineligible for federal financial participation (FFP) in Medicaid covered services.

As county officials now know, Medicaid FFP has long been available for inmates who are transferred from jail to a public hospital for inpatient hospital services that last 24 hours or more. And, NACo and NACBHDD have been advocating for an exception to the inmate exclusion for pre-adjudicated inmates who are held in jail while awaiting trial, and are thus presumed to be innocent.

While the recent letter does not offer help for pre-adjudicated individuals held in jail, [the letter and attached Q & A](#) do expand the Medicaid coverage options for individuals who are involved in criminal justice/correctional systems,

but who are not actually held in prisons or jails. “Regardless of the label attached to any particular custody status,” CMS explains that “an important consideration of whether an individual is an ‘inmate’ is his or her ability to exercise personal freedom.”

In a lengthy Q & A document attached to the letter, ***CMS clearly states that individuals are not subject to the inmate exclusion, and therefore are eligible for FFP for Medicaid covered services if they are in these non-jail situations:***

- Subject to home confinement or detention (e.g., ankle bracelet)
  - On parole
  - On probation
  - On community release, pending trial
  - Under pre-trial supervision
  - Temporarily and voluntarily in jail, post adjudication, while awaiting transfer to a “community residence.”
  - Residing in a “halfway house” or “supervised community residential facility” if individuals “have freedom of movement and association” as demonstrated by:
    - Ability to work at a job outside the facility
    - Ability to use community resources, at will\*
    - Ability to seek and choose health care treatment in the same way as other Medicaid enrollees
    -
- (\*CMS notes that individual freedom “includes and is consistent with” compliance with operational house rules, curfews, travel limitations, and other significant supervisory requirements.)

While this rule clarification create new opportunities for counties to utilize the Medicaid FFP to offset the costs of caring for justice involved individuals, counties must ensure that they have policies, procedures, and systems in place that will maintain the eligibility of justice-involved individuals until their dispositions—to jail custody or community-based resources—are known. Counties that suspend or terminate the Medicaid eligibility of an individual in custody too early may forfeit Medicaid matching funds for otherwise-covered care. Similarly, those who reinstate it too late in the release/reentry process hurt the chances of re-entering individuals to get the care needed to avoid recidivism.

In the Q & A section, CMS officials strongly suggest these policies for handling concerns associated with Medicaid eligibility for justice-involved individuals:

- 1) States should enroll or renew the enrollment of individuals before, during and after the period of time spent in the correctional facility.
- 2) Once enrolled, the state may place the inmate in a suspended eligibility status during the period of incarceration, or it may suspend coverage by establishing markers and edits in the claims processing system to deny claims for excluded services.
- 3) Whatever approach is used, the suspension must be promptly lifted when the inmate exclusion no longer applies, to assure timely access to coverage.

The document adds that enhanced federal funding is available for new or improved eligibility systems, per “Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, FR 2011-09340,” published April 2011.

## **2. Medicaid Managed Care Regulation modifies IMD exclusion**

Deep within the 1,500 pages of the Department of Health and Human Services’ new [Medicaid Managed Care regulation](#), (MMC) dated April 25, 2016, a targeted “Delivery System Reform” modifies the longstanding Medicaid “Institution for Mental Disease” (IMD) exclusion, which has prohibited payment of the Medicaid FFP for care

received by individuals aged 21-64 who receive inpatient care in facilities of over 16 beds that “are primarily engaged” in mental health or SUD treatment.

This delivery system reform now allows Medicaid FFP for inpatient and residential treatment of up to 15 days in a calendar month for mental health and SUDs for individuals aged 21-64 in facilities of 17 beds or more, provided that the care is delivered through a Medicaid Managed Care organization. At present, approximately 75% of Medicaid recipients are covered through managed-care organizations; the regulation does not apply in states that do not have managed care or that only have fee-for-service Medicaid systems.

In comments included with the MMC regulation, CMS acknowledged that the 15-day limitation might not be adequate for SUD treatment. For individuals requiring a longer length of stay, CMS offered guidance for service delivery system design in a State Medicaid Director Letter (SMD #15-003), dated July 27, 2015. This letter, found at [www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf](http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf), suggests that states create or modify 1115 demonstration waiver programs to meet the needs of individuals requiring additional SUD treatment options. California was the first state to successfully pursue this approach, and had its [Drug Medi-Cal Organized Delivery System \(DMC-ODS\) waiver](#) approved by CMS on August 13, 2015. Among other provisions, California’s plan offers a 90-day maximum length of stay, with a maximum of two stays per year, with treatment services provided according to guidelines from the American Society for Addiction Medicine (ASAM).

Numerous other states are now developing or amending their own 1115 proposals in hopes of gaining CMS approval for new SUD treatment options.

The new regulation takes effect July 1, 2017.

### **3. Accountable Health Community grants will help address social determinants of health**

First announced by the CMS Innovation Center in January, a new concept called “Accountable Health Communities” (AHC) will provide up to \$157 million in Medicaid grants to communities that will test whether systematically identifying and addressing the health-related social needs of beneficiaries will have an impact on improving health, improving health care quality, and reducing health care costs.

This grants program is unique because it will help grantee communities to screen Medicaid beneficiaries for social needs, and then evaluate how linking beneficiaries to services, resources, and opportunities outside of health care can have an impact on improving their health and well-being. The program is one of the first that seeks to relate outcomes in health care, one of the five Social Determinants of Health, with better access to four others: economic stability, physical environment, social and community relationships, and educational opportunities. At a minimum, the AHC model will specifically identify and address beneficiary health related social needs in five areas:

- Housing instability and insecurity
- Food insecurity
- Utility needs
- Eliminating interpersonal violence
- Meeting transportation needs.

The underlying idea behind the program is that participating communities will use grant funds to build community-wide screening, referral, service navigation, and service alignment to see whether these impact total health care costs, ED visits, inpatient admissions, and care quality for high-risk Medicaid beneficiaries. Program developers hope that linking beneficiaries with needed social and community supports such as food, housing, employment, and other services will help them to break the cycle of poverty and illness.

AHC grant recipient communities will be required to become a coordinating hub for efforts to:

- Identify and partner with clinical delivery sites such as clinics, hospitals;
- Conduct systematic health-related social needs screenings and make referrals for all eligible Medicare and Medicaid beneficiaries;
- Coordinate and connect community-dwelling beneficiaries who screen positive for certain unmet health-related social needs and who are randomized to the intervention group to community service providers that might be able to address those needs; and,
- Align model partners to optimize community capacity to address health-related social needs.

At present, CMS is evaluating the first round of community applicants to the program and is expected to announce grants to some 44 communities in December. You can find more information at

<https://innovation.cms.gov/initiatives/AHCM>.

## ACTION

All three reforms noted here represent important steps forward. Together with NACo, NACBHDD has actively supported all of these important reforms, and we are very grateful to regulators at CMS, who should be commended for their hard work and willingness to listen and respond. We have advocated for and supported these reforms for several years in several ways: 1) by creating a set of policy resolutions that form the basis of our advocacy; 2) by working directly with lawmakers on Capitol Hill to explain the importance and provide details about our resolutions, and 3) by working closely with experts in the field and our own county-based members to give regulators the best insights into possible solutions.

Below is a brief chart that outlines three of the NACo/NACBHDD resolutions that have helped to drive the regulatory reforms discussed here, along with a description of results gained so far and future results that we are seeking.

<b>NACo/NACBHDD Resolution Topic:</b>	<b>Results gained so far</b>	<b>Additional results currently being sought</b>
Changes to the inmate exclusion	CMS has clarified the exclusion (as noted above) to allow Medicaid FFP for justice-involved individuals who are not actually in a jail or prison cell.	Medicaid FFP for individuals incarcerated while awaiting trial.
Revisions to the Institutions for Mental Disease (IMD) Rule	Medicaid FFP for short-term inpatient hospital care (≤15 days per month) in managed care plans.	Medicaid FFP for non-hospital or residential care of up to 90 days per episode.
Maintenance of effort in county programs (e.g., coordination of medical, housing, employment, social supports)	\$157 million in new Accountable Health Communities Grants to build infrastructure that links beneficiaries with social needs to needed services.	Funded services that go beyond health care to provide essential social, employment, and housing supports so people can live healthy lives in the community.

As you continue to lead behavioral health services in your counties, we ask that you take the following actions:

- 1) Review CMS' clarifications on the inmate exclusion rule and challenge your colleagues in behavioral health and criminal justice to determine whether and how your county is making maximum use of the Medicaid FFP available for justice involved individuals.
- 2) Consider your local/state Medicaid procedures and determine how they are implemented when someone becomes an inmate – are benefits terminated or suspended? If suspended, is there a suspension of eligibility or a suspension in claims processing? And remember, you may qualify for federal funding for Medicaid eligibility system improvements.
- 3) Find out whether your state is developing or amending an 1115 waiver that can provide additional care options for individuals with SUDs. If so, what are the requirements for you and your provider network to participate? Learn about them and let providers know.
- 4) Learn more about the Accountable Health Communities Program and see who in your state or region has applied to participate. Grants will be announced in December.

***Researched and Written by Dennis Grantham***